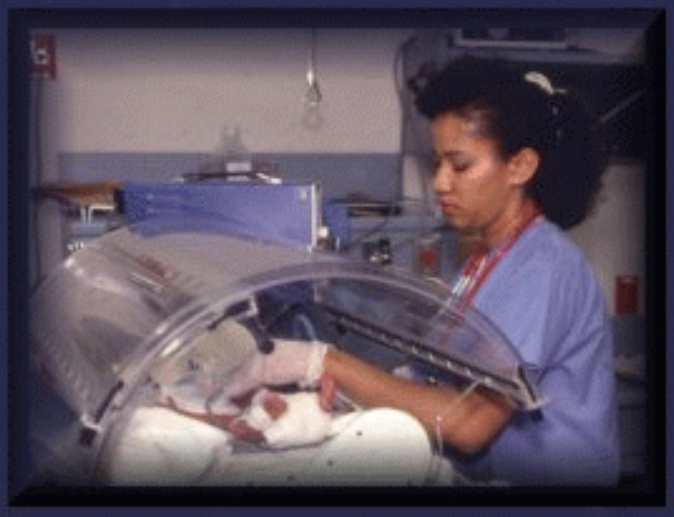
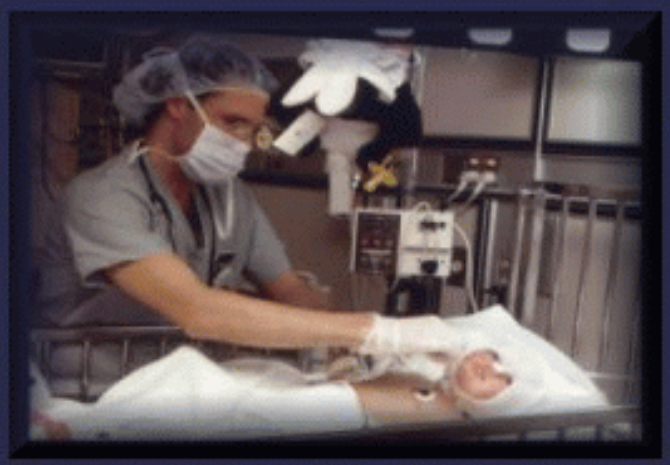
Report presented to the Joint Legislative Sunset Review Committee

1997-2001





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RESPIRATORY CARE BOARD

TABLE OF CONTENTS

PART 1.

RESPIRATORY CARE BOARD

BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM

BACKGROUND AND DESCRIPTION OF THE BOARD AND PROFESSION

BRIEF HISTORY AND FUNCTION OF THE BOARD

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law in 1982, thus establishing the Respiratory Care Examining Committee [In 1994, the name was changed to the Respiratory Care Board of California].

The Board was the eighth "allied health" profession created "within" the jurisdiction of the Medical Board of California (MBC). Although created within the jurisdiction of the MBC, the Board (previously a committee) had sole responsibility for the enforcement and administration of the chapter (Section 3710). At the time the Board was established, the MBC had a Division of Allied Health Profession (DAHP) designated to oversee the allied health committees. It was believed that this additional layer of oversight (in addition to the Department of Consumer Affairs) was unnecessary and ineffective. Therefore, the DAHP subsequently dissolved on July 1, 1994.

The first RCP license was issued in 1985. Nearly 10,000 applicants were licensed through a grandfather provision in 1985. As of June 30, 2001, nearly 22,000 licenses have been issued. Before issuing a RCP license, the Board ensures that applicants meet the minimum education and competency standards and conducts a thorough background check of each applicant.

The Board is mandated to protect the public from unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

The Board's mission is to protect and serve the consumer by administering and enforcing the Respiratory Care Practice Act and its regulations in the interest of the safe practice of respiratory care.

The Board's vision is to ensure that all stakeholders are aware of its mission and mandate to protect the public health, safety and welfare. Further, the Board is committed to

continuing to: 1) promote public awareness of its vision, mission and mandate, 2) encourage all consumers to continually and consistently be aware of their rights as health care patients, 3) explore advanced technology to improve communications and public awareness, 4) encourage all employers to honor their legal obligation to continually and consistently verify the licensure status of their RCP employees, 5) focus on pro-active enforcement by stringently screening each applicant, and preventing unqualified and/or incompetent individuals from entering the practice of respiratory care, 6) promptly investigate and adjudicate violations of law when committed, and 7) monitor RCPs on probation aggressively.

The respiratory care profession is a relatively young profession and has grown at a rapid rate. This is evident in part by the fact that the first professional association, now known as the American Association for Respiratory Care was founded over fifty years ago in 1947, with 59 members, and the current membership totals more than 36,000. This Association estimates that there are about 111,000 respiratory therapists in the United States. Of the 50 states, California alone contributes 14% of this figure. The U.S. Department of Labor projects an increase in demand for RCPs far greater than the average for all occupations through the year 2008.

Respiratory Care Practitioners treat patients with, but not limited to, chronic lung problems, such as asthma, bronchitis, and emphysema, but they also include heart attack and accident victims, premature infants, and people with cystic fibrosis, lung cancer, or AIDS. In each case, the patient will most likely receive treatment from a respiratory therapist (RT) under the direction of a physician. Respiratory therapists work to evaluate, treat, and care for patients with breathing disorders.

RCPs work with patients of all ages and in many different care settings. Most respiratory therapists work in hospitals where they perform intensive care, critical care, and neonatal procedures. They are also typically a vital part of the hospital's lifesaving response team that handles patient emergencies. Of the more than 7,000 hospitals in this country, about 5,700 have separate respiratory care departments. An increasing number of respiratory therapists are now working in skilled nursing facilities, physicians' offices, home health agencies, specialized care hospitals, medical equipment supply companies, and patients' homes.

Respiratory therapists perform procedures that are both diagnostic and therapeutic. Some of these activities include:

Diagnosis

- Obtaining and analyzing sputum and breath specimens. They also take blood specimens and analyze them to determine levels of oxygen, carbon dioxide, and other gases.

- Interpreting the data obtained from these specimens.

- Measuring the capacity of a patient's lungs to determine if there is impaired function.

- Performing stress tests and other studies of the cardiopulmonary system.

- Studying disorders of people with disruptive sleep patterns.

Treatment

- Operating and maintaining various types of highly sophisticated equipment to administer oxygen or to assist with breathing.

- Employing mechanical ventilation for treating patients who cannot breathe adequately on their own.

- Monitoring and managing therapy that will help a patient recover lung function.

- Administering medications in aerosol form to help alleviate breathing problems and to help prevent respiratory infections.

- Monitoring equipment and patient responses to therapy.

- Conducting rehabilitation activities, such as low-impact aerobic exercise classes, to help patients who suffer from chronic lung problems.

- Maintaining a patient's artificial airway, one that may be in place to help the patient who can't breathe through normal means.

- Conducting smoking cessation programs for both hospital patients and others in the community who want to kick the tobacco habit.

The need for respiratory care professionals is expected to grow in the coming years due to the large increase in the elderly population; the impact of environmental problems that have already contributed to the yearly rise in number of reported asthma cases; and technological advances in the treatment of heart attack, cancer, and accident victims, as well as premature babies.

[Reference: http://www.aarc.org/patient_education/whatarcp.html; "What is a Respiratory Therapist" July 5, 2001]

BOARD COMPOSITION

The Board has three appointing authorities, the Governor, Senate Rules Committee, and the Speaker of the Assembly. The Board consists of a total of 9 members, including 4 public members, 4 RCP members and 1 physician and surgeon member. Each authority appoints three members.

In the history of the Board, all Board members have been active participants, and almost every meeting has had 100% attendance. The current size of nine members promotes efficient decision making, while permitting each member to actively participate in the development of Board policy.

The Board is mandated to protect the public from the unauthorized and unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care. To fulfill its mandate, the Board has established and enforces statutes and regulations for public protection and amends those provisions, as needed, to provide greater consumer protection.

As of August 20, 2001, the Board's current appointments are as follows:

Governor Appointments
- Public Member: Vacant since 5/31/01
- Public Member: Vacant since 5/31/00
- RCP: Vacant since 5/31/00

Senate Rules Committee
- Public Member: Gary N. Stern, Esq.; Appointed: 9/19/98; Term Exp.: 5/31/05
- Physician & Surgeon: Richard L. Sheldon, M.D., Appt.: 4/6/99; Term Exp.:5/31/02
- RCP: Barry Winn, Ed.D., RCP; Appointed: 6/20/90; Term Exp.: 5/31/02

Speaker of the Assembly
- Public Member: Gopal Chaturvedi; Appointed: 06/29/01; Term Exp.: 5/31/04
- RCP: Larry L. Renner, RCP; Appointed: 7/12/01; Term Exp.: 05/31/03
- RCP: Vacant since 5/31/01

COMMITTEES

The Board has established two-member committees to enhance the efficacy, efficiency and prompt dispatch of duties upon the Board. They are as follows:

Executive Committee
Barry Winn, Ed.D., RCP, President and (vacant since 5/31/01), Vice-President

The Executive Committee consists of the president and vice-president of the Board. As elected officers, this committee may make interim (between Board meetings) decisions as necessary. This committee also provides guidance to administrative staff for the budgeting and organizational components of the Board.

Education Committee
Barry Winn, Ed.D., RCP, Chair and Gopal Chaturvedi, Member

Members of the Education Committee are responsible for the review and development of regulations regarding the educational requirements for initial licensure and continuing education programs and makes recommendations to the full Board. Essentially, they monitor various education criteria requirements for licensure, taking into consideration ever-changing, as well as new developments in technology and managed care.

Enforcement Committee
Barry Winn, Ed. D., RCP, Chair and Gary Stern, Esq., Member

Members of the Enforcement Committee are responsible for the development, review and continued refinement of Board-adopted policies, positions and Disciplinary Guidelines and make recommendations to the full Board. Although the members of the Enforcement Committee do not review individual enforcement cases (if they do they recuse themselves from any further proceedings), they are responsible for policy development for the overall management of the enforcement program, pursuant to the provisions of the Administrative Procedure Act (APA).

Legal/Legislative Affairs Committee
Gary N. Stern, Esq., Chair and (vacant since 5/31/01), Member

Members of the Legislative Affairs Committee are responsible for identifying, tracking, and making recommendations to the Board with respect to legislation impacting the Board program, consumers, and the practice of respiratory care. In consultation with legal counsel, the Board staff, other interested parties and members develop legislative and regulatory language, propose/recommend legislative or regulatory changes, and identify statutory needs and make recommendations to the full Board.

Professional and Community Relations Committee
(Vacant since 5/31/01), Chair and Richard Sheldon, M.D., Member

Members of the Professional and Community Relations Committee are responsible for the development of consumer outreach projects, including the Board's newsletter, website, and outside organization presentations and make recommendations to the full Board as needed. These members act as good will ambassadors and represent the Board at the invitation of outside organizations and programs.

Professional Licensing Committee
Richard Sheldon, M.D., Chair and Larry Renner, RCP, Member

Members of the Professional Licensing Committee identify needs for reform, revision, and development of policies to strengthen the Board's licensing program. This committee addresses scope of practice issues and presents responses to the full Board for final approval.

Task Forces
When a specific issue arises that is exigent or necessitates specific expertise, the Board has formed various task forces to deal with the matter. Examples of previously established task forces are the Education Task Force, which reviewed educational requirements and the feasibility of raising education standards and the Sunset Review and Regulation Review Report Task Force to oversee the preparation of the Sunset Report.

Organizational Chart
On the following page is the Board's organizational chart as of August 20, 2001.

LICENSEES / TITLES / REGULATIONS

The Board has one license type, respiratory care practitioner. The Respiratory Care Practice Act is comprised of Business and Professions Code Section 3700, et. seq. and California Code of Regulations, Title 16, Division 13.6, Article 1, et. seq..

MAJOR CHANGES SINCE LAST SUNSET REVIEW

The Board has had several significant changes since its last sunset review as follows:

Legislative Amendments

Business and Professions Code (B&P) Sections 3711 and 3712 were amended to reduce the number of physicians and surgeons appointed to the Board from 2 to 1 and increase the number of public members from 3 to 4.

B&P, Section 3717 was amended to allow enforcement staff, in addition to other personnel, inspect respiratory care facilities and treatment. The section was also amended to allow the inspection of employment records.

B&P, Section 3719 was amended and increased the maximum number of continuing education hours the Board can require for renewal, from 15 to 30 hours.

B&P, Section 3750 was amended to include incompetence and a pattern of substandard care as causes for disciplinary action.

Section 3750.51 was added to the B&P, which provides time limitations to file an accusation against a licensee.

Sections 3758, 3758.5, 3758.6, and 3759 were added to the B&P and provide that employers and other licensed respiratory care practitioners shall report to the Board violations of the Respiratory Care Practice Act (a.k.a. Mandatory Reporting).

B&P, Section 3765 was amended to provide that formally trained licensees and staff of child day care facilities would not be prohibited by the Respiratory Care Practice Act, to administer to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

B&P Section 3775 was amended to raise the ceiling of several fees and place a cap on the Board's fund to approximately 6 months of annual authorized expenditures.

Section 3775.2 was added to the B&P, which provides fees for the approval of providers of continuing educations.

Education Requirements Increased
Effective July 1, 2000, the minimum education standards for Respiratory Care Practitioners increased to an Associate Degree requirement by way of regulation. In addition to the required degree, the Board established specific curriculum requirements.

Daily Exam Administration
In January 2000, the National Board for Respiratory Care implemented daily computer-based testing. In July 2001, the Board began administering this examination directly through its contracted test centers located throughout California. Computerized daily testing allows candidates to sit for the examination throughout the calendar year and become licensed much faster than before. Further, applicants can receive their examination scores on the same day they take their licensing examination.

Continuing Education Provider Approval
The Board is moving forward with regulations to implement its approval for continuing education providers. The Board has placed an emphasis on ensuring that the continuing education completed by respiratory care practitioners is of high caliber. The program is expected to be in place by the early part of 2002.

Probation Program Re-Directed
The Board assumed direct responsibility and oversight for its Probation Monitoring Program, in Fall, 1998, which was previously administered by the Division of Investigation. It was determined that analysts could provide oversight of its probationers at a cost much less than that of investigators.

As a result of the new unit, the Board is more confident that it is ensuring the adequate protection of patients while allowing practitioners to practice with reasonable skill and safety. When a probationer successfully completes probation, she/he understands what is expected from a professional licensee and is far less likely to re-enter the disciplinary system.

Probation Program Award
In September 2000, the Board was presented a Program Award for its vision, creativity, and effectiveness in operating an exemplary probation program from the Council on Licensure, Enforcement and Regulation (CLEAR). Each year CLEAR recognizes a program for the performance of exemplary service by a professional regulatory agency, which has enhanced professional regulation and consumer protection.

Office Move
The Board office relocated from its original site at Howe Avenue to 444 North 3rd Street, Sacramento, CA 95814 in April 2001. This move proved to be extremely successful by allowing the Board the adequate office and storage space it requires to conduct its day-to-day business.

Executive Officer Resignation
Cathleen A. McCoy, the previous Executive Officer of the Board, resigned in March 2001 to pursue another State government opportunity. Ms. McCoy was the Board's Executive Officer for nearly 11 years and was instrumental in advancing consumer protection. She received several awards and recognition for her contributions towards consumer protection.

Website
To further its consumer outreach efforts, the Board was pleased to announce the establishment of its website (www.rcb.ca.gov) on June 29, 2001. The website was the first developed to meet and pass the Governor's website guidelines. The Board, via the Department of Consumer Affairs, is developing its own "license look-up" that should be implemented by July 1, 2002. The license look-up will enable anyone with access to the Internet to look up the status of RCP licenses.

The site offers valuable information to applicants, licensees, hospitals, and consumers. Highlights include: the ability to access many of the Board's regularly utilized forms including forms to verify license status; the ability for consumers and employers to view recent disciplinary actions taken by the Board; the availability to easily reference the laws and regulations which govern the practice of respiratory care; and access to Board information such as upcoming meeting dates and locations.

Strategic Planning
Since the last sunset review, the Board has updated its Strategic Plan on a bi-annual basis. The four program areas with goals and objectives include Enforcement, Public Relations, Licensing, and Administration.

MAJOR STUDIES

At the Board's August 10, 2001 Board meeting, discussion ensued regarding the lack of regulatory oversight for Home Medical Device Providers, Pulmonary Function Technicians, and Polysomnography Technicians (sleep studies).

Concern has been expressed that there is no quality control and that unlicensed and unqualified personnel are performing tasks in these areas. The Board agreed to arrange a meeting with other representatives to develop a plan of action to evaluate the need for oversight for these functions as it pertains to consumer protection.

LICENSING DATA

Through the end of FY 2000/01, there have been approximately 22,000 RCP licenses issued. If queried, the Board provides public information regarding a licensee, which may include: the license number, name, issue date, date of license expiration, and dates renewed. The Board always discloses any disciplinary action in accordance with its Complaint Disclosure Policy. The following provides licensing data for the past four years:

LICENSING DATA FOR RCPs	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Licensed California* Out-of-State*	Total: 20,137 18,414 1,723	Total: 20,843 19,000 1.843	Total: 21,480 19,529 1,951	Total: 21,942 19,912 2,030
Applications Received	Total: 722	Total: 849	Total: 614	Total: 397
Licenses Issued	Total: 703	Total: 706	Total: 637	Total: 462
Renewals Issued	Total: 6,310	Total: 6,373	Total: 6,457	Total: 6448
Statement of Issues Filed	Total: 5	Total: 9	Total: 21	Total: 9
Statement of Issues Withdrawn	Total: 0	Total: 0	Total: 1	Total: 1
Licenses Denied	Total: 13	Total: 1	Total: 2	Total: 4

* These are estimated based on percentages of applications received, less grandparent licensees (10,000). An average of 17% of applications received are from out-of-state.

BUDGET AND STAFF

CURRENT FEE SCHEDULE AND RANGE

The Respiratory Care Board of California (Board) is a special fund organization. All revenue is generated by the Board through various fees which are either specific in statute or have a range with a ceiling cap and then are specifically delineated through regulation. Following are the Board's current fees, fee changes that will take effect January 1, 2002, and statutory limits:

➡

Fee Schedule	Current Fee	Fees Effective 1/1/02	Statutory Limit
Application Fee	$200	$200	$300
Out-of-State Application Fee	$250	$250	$350
Examination Fee	$190	$190	Actual Cost
Re-Examination Fee	$150	$150	Actual Cost
Initial License Fee	$200	**$48-$136**	$300
Renewal Fee	$200*	**$230**	$330
Renewal Delinquency Fee	$200	**$230**	$330
Duplicate License Fee	$ 75	**$25**	$75
Endorsement Fee	$100	**$75**	$100
Transcript Review Fee	$100	**$75**	Actual Cost
CE Provider –Initial Fee	$700	$700	$700
CE Provider-Renewal	$350	$350	$350
CE Provider – Delinquent	$175	$175	$175
CE Provider-Amendments	$350	$350	$350

*The statute actually provides that the renewal fee shall be $230. The Board has not yet implemented this fee increase – see discussion.

The Board's main source of revenue is derived from its license renewal fee. License renewal is required every two years and currently that fee is $200. In 1998, the actual fee and cap for the renewal fee was increased (1998, Ch. 991 – SB 1980, Greene). Section 3775, subsection (d) provides that for any license term beginning on or after January 1, 1999, the renewal fee shall be established at $230 and that the Board may increase this fee not to exceed $330. However, due to the fluctuation of the Board's budget and reserves, the implementation of the $230 renewal fee was postponed. The Board anticipates implementing this fee effective January 1, 2002 in order to maintain a solvent fund through FY 04/05.

Due to the shortage of RCPs and its ultimate impact on the safety of consumers, the Board recently reviewed its applicant-related fees to see if front-end costs could be reduced to accommodate new students into the field.

The initial license is currently issued for a period of 12 to 23 months for a flat fee of $200, regardless of the number of months the license is issued. The Board has adopted with its authority under section 3775(k), to reduce its initial license fee by prorating the fee at $8 per each month of the initial license and reducing the length of the initial license from 12 to 23 months to 6 to 17 months, effective January 1, 2002. Therefore, the minimum amount due will be $48 and the maximum will be $136.

The Board has also moved to reduce its transcript review fee from $100 to $75 effective January 1, 2002. Since the implementation of transcript review in 1996, and the change in education requirements that took effect July 1, 2000, the Board has found that the transcripts from California schools offering respiratory care programs, which previously had numerous discrepancies, have few today. Therefore, the staff work involved in denying applications or rectifying discrepancies has reduced. The Board will be taking a closer look at this process in 2002 to determine if there is a more cost-effective and efficient manner to confirm that students are in fact meeting the Board's educational requirements.

These fee reductions, although significant to students, have a minimal impact on the Board's budget. [Note: An informal survey conducted in July, 2001 revealed that program directors of California respiratory care programs do not believe that applicant fees are associated with low enrollment in their programs. However the lower fees will assist students enter the respiratory care field after graduation more quickly].

The Board also approved a motion to reduce its duplicate license fee from $75 to $25 and its endorsement fee from $100 to $75. These revenue sources have little activity and the reductions were made to simply align the fees with other boards' and to provide licensees with a more feasible rate to replace a lost or stolen license.

It is estimated that all of the fore mentioned fee reductions will be an approximate loss of revenue of $30,000 annually. Whereas, the renewal fee increase is expected to generate an additional $192,000 in annual revenue. It was determined that with or without the fee reductions, the Board would still need to implement the increased renewal fee in order to maintain a solvent fund.

REVENUE AND EXPENDITURE HISTORY

As stated earlier, the Board is a special fund agency. All revenue is generated by the Board through various fees as specified above.

As indicated in the following chart, the Board is projecting to collect over 2 million in revenue in fiscal years 01/ 02 and 02/03. In FY 00/01, there was substantial loss in revenue which was directly associated with a temporary reduction in applicants. This reduction was a one-time event and was the result of the Board increasing its educational requirements from a one-year program to a two-year degree program.

The following revenue projections include the additional revenue generated from the implementation of the renewal fee at $230 effective January 1, 2002 and the implementation of continuing education provider approval, which is expected to be implemented early in 2002.

REVENUES	ACTUAL				PROJECTED	
	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03
Licensing/Renewal	1,393,493	1,466,388	1,487,726	1,436,403	1,665,425	1,754,150
Application/Examination	287,524	356,677	208,981	130,100	326,500	351,000
Fines	24,000	14,400	23,367	14,400	15,000	15,000
Other	3,297	2,503	3,681	4,355	3,500	3,500
Interest	19,316	49,088	80,223	117,954	64,000	54,520
TOTALS	**1,727,630**	**1,889,056**	**1,803,978**	**1,703,212**	**2,074,425**	**2,178,170**

The Board's expenditures, both actual and projected, have fluctuated greatly each year. This is in large part due to the way in which investigations are billed, the implementation of mandatory reporting laws, and the one-time lull of new applications received.

The DOI charges its clients on a rollover method, which essentially estimates that year's spending and adjusts for any over or under expenditures from two years earlier. The method has proven to be beneficial, and once workload is established, the amount does not fluctuate as much. However, the Board began using DOI services in FY 94/95, and entered into an agreement to include the monitoring of its probationers in FY 96/97. In FY 98/99 the monitoring of probationers was re-directed to the Board, again requiring adjustments from the DOI line item and increasing personnel services for the Board. The expenses incurred for investigations declined in FY 98/99 as a result of overpaying two years previously. Expenses for investigation begin to increase and level off as the workload is now becoming established at a more even rate.

On January 1, 1999, new mandatory reporting requirements were established (reference: B&P sections 3758, 3758.5, 3758.6). As a result, expenditures associated with promoting the new laws and processing complaints increased. It is expected that awareness of the new laws will come full circle by the end of this year. So not only will the number of complaints received continue to increase, but also the costs associated with processing these types of complaints. These complaints generally accumulate costs associated with formal investigation, expert review and attorney costs. Whereas, other complaints, such as the receipt of rap sheets, generally only accumulate attorney general costs.

In FY 00/01, expenditures were lower than what would normally be expected due to the reduction in applications received. As a result of the Board increasing its educational requirements effective July 1, 2000, few examinations were scheduled in FY 00/01, hence a reduction in examination expenditures. The number of applications received is expected to increase to the "normal" level this fiscal year (FY 01/ 02).

In FY 02/03, it is projected that total expenditures ($2,427,040) will exceed total revenues ($2,178,170) by nearly $249,000. There are several fees that could be increased to their statutory maximums (which would far exceed this difference) if spending patterns remain constant. However, the Board is committed to exploring other mechanisms to reduce expenditures (revising its enforcement guidelines, enhancing it cite and fine program, etc…), so that fees do not have to be increased.

EXPENDITURES	ACTUAL				PROJECTED	
	FY 97-98	FY 98-99	FY 99-00	FY 00-01	FY 01-02	FY 02-03
Personnel Services	556,730	609,141	702,381	903,343	1,257,150	1,320,008
Operating Expenses	1,435,479	1,026,373	999,396	1,245,557	1,342,850	1,307,032
TOTAL EXPENDITURES	1,992,208	1,635,514	1,701,777	2,148,900	2,600,000	2,627,040
(-) Reimbursements	236,116	244,174	223,096	215,355	200,000	200,000
TOTALS	**1,756,092**	**1,391,340**	**1,478,681**	**1,933,545**	**2,400,000**	**2,427,040**

EXPENDITURES BY PROGRAM COMPONENT

Over the last four fiscal years, the Board has expended an average of 71.7% of its budget on enforcement. During the last Sunset Review, this figure was higher at 84%. Further, in the most recent fiscal year, (FY 00/01) 70% of the Board's total expenditures were attributed to enforcement.

The Board has made significant strides to reduce enforcement expenditures and still maintain consumer protection. In fact, the Board is planning another review of expenditures vs. complaint types to ensure that the complaints received from the new mandatory reporting laws take precedence (over rap sheets and DMV history printouts that reveal single driving under the influence convictions). Although, the Board does discipline applicants and licensees for driving under the influence, it has set guidelines (since the last Sunset Review), providing to pursue discipline only if a person has 1 or more DUIs within three years or 2 or more DUIs within 5 years. Due to the increase in complaints (from mandatory reporting) involving inappropriate conduct in direct relation to the practice of respiratory care, the Board is again, reviewing its disciplinary guidelines early next year (2002) to ensure that monies dedicated to enforcement are available for high priority cases.

EXPENDITURES BY PROGRAM COMPONENT	FY 97-98	FY 98-99	FY 99-00	FY 00-01	Average % Spent by Program
Enforcement	1,474,234	1,161,215	1,225,279	1,504,230	**71.7%**
Examination / Licensing	278,909	245,327	255,267	343,824	**15%**
Administrative	239,065	228,972	221,231	300,846	**13.25%**
TOTALS	**1,992,208**	**1,635,514**	**1,701,777**	**2,148,900**	

FUND CONDITION

The following fund condition includes projected revenue from the renewal fee increase (effective 1/1/02) and implementation of continuing education providers. With this additional revenue, the Board's expenditures will exceed its revenues by approximately $249,000 in FY 02/03. However, reserves are high enough [without exceeding the 6-month limit as required in Section 3775(d)] to provide a fiscally sound fund through FY 04/05.

The Board has several fees with higher statutory maximums that would more than compensate for future projected deficits. However, the Board is committed to not increasing fees and exploring other avenues to reduce expenditures. For the time being, the Board's fund is sound, however the Board is aware that changes need to take place within the next two to four fiscal years to maintain solvency.

ANALYSIS OF FUND CONDITION	FY 99-00	FY 00-01	FY 01-02	FY 02-03 (Projected)	FY 03-04 (Projected)	FY 04-05 (Projected)
Total Reserves, 7/1	1,209,000	1,470,319	1,415,970	1,090,395	841,525	552,890
Total Rev & Transfers	1,804,000	1,879,196	2,074,425	2,178,170	2,165,726	2,151,295
Total Resources	2,949,000	3,349,515	3,490,395	3,268,565	3,007,251	2,704,185
Budget Expenditure	1,701,777	2,148,900	2,600,000	2,627,040	2,654,361	2,681,966
Reimbursements	223,096	215,355	200,000	200,000	200,000	200,000
Total Expenditures	1,478,681	1,933,545	2,400,000	2,427,040	2,454,361	2,481,966
Reserve, June 30	1,470,319	1,415,970	1,090,395	841,525	552,890	222,219
MONTHS IN RESERVE	**6.9**	**5.8**	**5.5**	**4.2**	**2.7**	**1.1**

Note: Expenditure growth projected at 4% beginning FY 02/03

LICENSURE REQUIREMENTS

EDUCATION

Effective July 1, 2000, all applicants for licensure in California are required to meet the minimum education standards, which have been increased to an Associate Degree requirement. Applicants must demonstrate completion of no less than 42 semester units in science and respiratory care prerequisites, and laboratory and student clinical practice as follows:

a). Basic sciences
b). Clinical sciences
c). Respiratory Care Content Areas
d). Clinical Practice shall be at least 800 hours.

[Reference: California Code of Regulations (CCR) section 1399.330]

Each program's course instruction is required to be based on a structured curriculum, which clearly delineates the competencies to be developed and the methods by which they are to be achieved. The curriculum goals and standards are designed to provide students with the requisite knowledge, skills and behaviors to ensure practitioner competencies expected for licensed entry into the respiratory care practice.

EXPERIENCE

Currently, there is no experience requirement, which must be fulfilled prior to licensure. However, as specified in CCR section 1399.330 (c) students are required to complete at least 800 hours of clinical practice as part of their structured curriculum. The clinical practice is based on an instructional plan, and offers clinical practice exercises and opportunities of sufficient volume and variety to ensure attainment of competencies prescribed by the structured curriculum.

EXAMINATION

Applicants for licensure are required to take and pass an examination. Business and Professions (B&P) Code section 3736 allows the Board to utilize a uniform examination system. Currently, the Board has a contract with the National Board for Respiratory Care (NBRC) to utilize its entry level Certified Respiratory Therapist (CRT) examination as the State licensing examination. The NBRC conducts an occupational analysis once every five years in order to validate the examination. Every exam question can be directly linked to a task on the analysis that was identified as a duty of the entry level Respiratory Care Practitioner. The exam has been validated both on content and criterion-related (predictive) validity. The NBRC has established a pool of Content Expert/Item Writers selected to participate in the development of current examination questions.

Further, in October 2000, the Department of Consumer Affairs (DCA), Office of Examination Resources (OER), completed an evaluation of the content of the CRT examination to determine the adequacy for entry-level practice in California as a result of the increased educational requirement, which was effective July 1, 2000. The OER determined that the examination was adequate for assessing minimum competence. The NBRC will require an associate degree for all of its credential applicants after January 1, 2006. This increase is based on the Committee on Accreditation for Respiratory Care changing its education standards, which requires all accredited education programs (nation-wide) to award a minimum of an associate degree to all students enrolled on or after January 1, 2002.

Although the Board has a contract with the NBRC for use of its CRT examination as the State licensing examination, the Board also has a contract with Experior Assessments, Inc. (Experior) via the Master Services Agreement with DCA, to administer the examination. Licensing examinations are administered in a computer-based format and are given on a daily basis at sites located throughout California including: Diamond Bar, Alameda, Sacramento, San Diego, Fresno, Fremont, Rancho Cordova, Van Nuys, Cerritos, and Colton.

There are many benefits to computerized daily testing, including the ability to sit for examinations throughout the calendar year which allows the applicant the opportunity to become licensed much faster than before. With computer-based testing, applicants are provided their examination scores at the exam site on the day they take their licensing examination.

APPLICATION PROCESSING

Once an application packet is received, it is assigned to a staff member who reviews and processes the application.

Transcript Review

All applicants must have their official transcript sent from all programs or colleges from which they have acquired education leading to the award of the required associate degree. Board staff reviews each transcript to ensure that the course curriculum meets the requirements set forth in CCR sections 1399.330 and 1399.331. If, for any reason, a discrepancy exists between the transcript and the required curriculum, the applicant is notified of the specific area of deficiency. A license to practice respiratory care is not issued until all transcripts are received and approved by the Board.

Background Checks

The Board requires each candidate for licensure to submit his or her fingerprints for state and federal background processing. Applicants are urged to use Live Scan, an electronic imaging process that does not require fingerprint cards, in order to expedite the criminal record check for both the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI). Further, the Board also requires a Department of Motor Vehicles history printout as part of its application process.

DOJ Background Check

The Department of Justice (DOJ) runs a background clearance by checking conviction files against the applicant's name, social security number, California Driver's License number, and fingerprint patterns. The DOJ only provides information regarding convictions received in the State of California. Once an applicant has submitted his/her application for licensing purposes, the DOJ provides updates on subsequent criminal history, should it occur.

The Board's policy is to issue an Applicant Work Permit only after a criminal record clearance has been received from the DOJ. This provides an extra assurance that the Board is not issuing a work permit to an individual who has a prior criminal conviction and has committed perjury on his/her application.

FBI Background Check

Through the DOJ, the Board also requests clearance from the Federal Bureau of investigation. Background clearance is accomplished by checking conviction files against the applicant's name, social security number and fingerprint patterns. The FBI provides information regarding convictions received anywhere within the United States, however, the information provided is only accurate up to the day it issued. Further, unlike the DOJ, the FBI does not send updates or information on subsequent criminal activity.

Department of Motor Vehicles Background Check

All applicants are required to submit a Department of Motor Vehicles (DMV) driving history as part of the application process. The DMV printout allows the Board to determine if an individual applying for licensure has any Driving Under the Influence of alcohol or drugs or Reckless Driving (alcohol involved) convictions, as these types of convictions do not normally appear on DOJ "rap sheets" unless the DUI caused injury or death. The Board is also able to determine whether or not there are any warrants for arrest or other relevant charges pending, which must be rectified prior to licensure.

Enforcement Unit Referral

If it is revealed through any one or more of the background checks that the applicant has one or more criminal convictions or if the applicant marks "yes" to certain questions on the application, the file is referred to the enforcement unit for further investigation. On the application, the applicant is required to disclose conviction information, as well as information related to any license ever held and if any disciplinary action has ever been taken against any other license held.

CALIFORNIA LICENSING EXAMINATION

As previously indicated, the Board utilizes the NBRC's CRT examination as the California state licensing examination for RCPs. The CRT examination is designed to objectively measure essential knowledge, skills and abilities required of entry level RCPs. Based on

the required knowledge, skills and abilities, the exam matrix is divided into the three major performance areas with the cognitive complexity level defined as follows:

* Recall: The ability to recall or recognize specific respiratory therapy information.

* Application: The ability to comprehend, relate, or apply knowledge to new or changing situations.

* Analysis: The ability to analyze information, to put information together to arrive at solutions, and/or to evaluate the usefulness of the solutions.

The table below provides information on the candidate volume and pass rate for national exam candidates in comparison to California exam candidates. Please note that the data reflects examination results for both first-time and repeat candidates. The national data likely includes a larger percentage of repeat candidates than does the California specific information.

CERTIFIED RESPIRATORY THERAPIST EXAMINATION				
YEARS	NATION-WIDE		CALIFORNIA ONLY	
	TOTAL CANDIDATES	PASSAGE RATE	TOTAL CANDIDATES	PASSAGE RATE
1997/98	10,027	54.42%	748	71.93%
1998/99	9,470	57.23%	720	70.42%
1999/00	9,938	47.78%	1,160	55.17%
2000/01	7,021	51.29%	556	51.44%

The NBRC last conducted a job analysis for the CRT examination in 1997. The most significant change in the examination based on the most recent job analysis was that the complexity level distribution of the examination questions shifted to reflect a higher percentage of “application” and “analysis” questions. The NBRC conducts job analysis studies every five years. The next national job analysis study for the CRT examination is scheduled for 2002.

It is important to note that based on the 1997 job analysis, new test specifications were introduced in July, 1999 and that a transition to computer-based testing occurred in January, 2000 and may have caused fluctuations in the candidate volume for both national and California candidates.

The following chart indicates the average number of days to process an application for licensure. Since the implementation of daily testing in 2000, processing time has reduced significantly from 139 to 85 days. However, the Board is encouraging applicants (as of August, 2001) to apply for examination closer to 90 days prior to the date of eligibility. This assists those applicants with enforcement backgrounds (that are not subject to the denial of

his/her license) to obtain an enforcement clearance and obtain licensure as soon as possible after examination. Therefore, future processing times from" Application to Examination" may increase.

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AVERAGE DAYS TO RECEIVE LICENSE	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Application to Examination	86.5	86	74.6	52.2
Examination to Issuance	52.2	42.7	56	32.3
Total Average Days	**138.7**	**115.3**	**130.6**	**84.5**

CONTINUING EDUCATION/COMPETENCY REQUIREMENTS

The requirements for Continuing Education (CE) are detailed in CCR sections 1399.350, 1399.351, 1399.354, 1399.355, and 1399.356. Currently, a RCP must complete 15 hours of CE for each renewal period. The courses must be relevant to the practice of respiratory care and at least two-thirds must be directly related to clinical practice.

Pursuant to CCR section 1399.352, the Board randomly audits licenses to ensure compliance with CE requirements. By performing random audits of licensees who must document the continuing education courses submitted for license renewal, the Board is able to provide scrutiny and controls in an attempt to ensure that courses taken are directly related to the clinical practice of the respiratory care profession.

Over the years, the Board has made education requirements more stringent for both applicants and licensees. In light of the increased education standards for applicants, discussion ensued regarding the need to increase CE units required for license renewal. Therefore, in 1999, the statutory ceiling of the number of CE hours was increased from 15 to 30 units every renewal period (B&P section 3719).

One of the Board's Licensing goals is to ensure that licensees maintain the current professional knowledge and standards for competent performance. This element of the program supports the Board's mission and statutory CE mandate. Improving competence helps mitigate practice problems, which feasibly could lead to complaints or subsequent disciplinary action. In other words, this is proactive enforcement.

While the Board has always maintained the statutory authority to approve CE providers, it had not previously gone forward with implementing a formal CE provider/course approval program. Instead, the Board set, in regulation, the criteria of acceptability for courses obtained as part of a licensee's renewal requirement. However, the Board has recently determined the need to implement a formal CE provider approval program as it is concerned with the coursework offered to RCPs, due to the complexity and critical nature of the scope of practice or respiratory care.

COMITY/RECIPROCITY WITH OTHER STATES

Currently, the Board recognizes and accepts the NBRC credential in lieu of passage of the State licensing examination, however education requirements must also be met and background checks performed prior to license issuance. Further, verification of licensure, including discipline history, is required from each state where the applicant has been licensed. Once an out-of-state candidate submits his/her application, provided there are no potential enforcement related issues, an Applicant Work Permit is issued to the applicant to allow employment during the remaining application process. Applicants are kept apprised of deficient items throughout the application process to ensure the licensing process is completed as expeditiously as possible.

Foreign-trained applicants are required to forward their original transcript to an approved evaluation service for an equivalency evaluation. Upon completion of the evaluation, the service forwards a report directly to Board. If applicable, the evaluation requirement is in addition, to the official transcripts that must be submitted to Board directly from the educational institution leading to the award of a degree. In order to properly evaluate the transcript(s) all coursework completed must be included. If the foreign training is determined to be equivalent to the minimum education requirements set forth in CCR sections 1399.330 and 1399.331, the foreign-trained applicant is scheduled to take the State licensing examination. Applicant Work Permits are also provided to foreign-trained applicants, again to allow employment during the application process, provided there are no enforcement related issues, which may affect the applicant's potential for licensure.

ENFORCEMENT ACTIVITY

ENFORCEMENT DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Complaints Received (Source)	Total: 225	Total: 232	Total: 182	Total: 239
Public	18	17	19	35
Licensee/Professional Groups	23	5	11	87
Governmental Agencies	121	141	38	56
Other	63	69	114	61
Type of Complaints Closed	Total: 259	Total: 261	Total: 225	Total: 216
Competence/Negligence	6	5	13	12
Unprofessional Conduct	8	23	16	9
Fraud	13	12	18	9
Unlicensed Activity	14	8	10	41
Substance Abuse/Drug Related	82	59	22	17
Criminal Convictions	104	148	134	119
Sexual Misconduct	10	4	5	2
Other	22	2	7	7
Internal Investigations Commenced	225	232	182	239
Formal Investigations Commenced	17	19	38	21
Compliance Actions	Total: 163	Total: 166	Total: 82	Total: 70
ISOs & TROs Issued	3	1	1	1
Citations and Fines	39	24	14	14
Public Letter of Reprimand	6	7	7	8
Cease & Desist/Warning	115	134	60	47
Referred for Criminal Action	1	1	2	4
AG's Office Activity	Total: 109	Total: 101	Total: 139	Total: 117
Statement of Issues Filed	5	9	21	9
Accusation and/or Petition to Revoked Filed	30	25	38	23
Accusations Filed	74	67	78	82
Accusation Withdrawn/Dismiss	0	0	2	3
Decisions (by Type)	Total: 114	Total: 91	Total: 101	Total: 148
Stipulated Settlements	73	49	62	87
Proposed Decisions	21	20	13	27
Default Decisions	20	22	26	34
Disciplinary Actions	Total: 114	Total: 91	Total: 101	Total: 148
Revocation	34	34	34	51
Voluntary Surrender	9	6	11	12
Licenses Denied	13	1	2	4
Probation with Suspension	0	3	3	1
Probation	52	40	44	72
Public Reprimand	6	7	7	8
Probation Violations (1)	Total: 26	Total: 28	Total: 28	Total: 31
Suspension or Probation	5	4	5	4
Revocation or Surrender	21	24	23	27

NOTES
(1) These figures are also included under "Disciplinary Actions."

Though telephone inquiries are not tracked, it is estimated the Board receives 13,000 written and oral enforcement inquiries each year. The type of inquiries frequently received are requests for copies of legal administrative disciplinary actions, license status /case updates, complaint forms, information on laws and regulations and questions on the disciplinary process and probation orders.

ENFORCEMENT PROGRAM OVERVIEW

The Business and Professions Code (B&P) authorizes the Board to deny licensure and/or take appropriate disciplinary action against any individual found to have violated any provision of law. Violations range from convictions of crimes related to the practice of respiratory care (i.e., sexual misconduct, alcohol and/or drug abuse or convictions, or inflicting bodily injury or attempted bodily injury) to negligent and/or incompetent practice.

Since the inception of the Board, most complaints received have been a result of the receipt of Criminal Identification Information reports or better known as "rap sheets" obtained from the DOJ and/or the FBI. However, in the last fiscal year, the largest number of complaints received was from licensees and employers. This is a direct result of the Board's new mandatory reporting laws (1198, Ch. 553 – AB 123, Wildman). As a result of a very publicized case, "the angel of death," the Board was approached by Assemblyman Wildman's office, 1998, to author mandatory reporting legislation for the Board.

AB 123 (Statutes of 1998, Chapter 553) added sections 3758, 3758.5, 3758.6 and 3759 to the Business and Professions Code, which provide in part, that all employers shall report to the Board any termination or suspension for cause and all licensees shall report any person that may have or has violated any of the statues or regulations administered by the Board. Specifically those statutes read:

> **3758**. (a) Any employer of a respiratory care practitioner shall report to the Respiratory Care Board the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.
> (b) For purposes of the section, "suspension of termination for cause" is defined to mean suspension or termination from employment for any of the following reasons:
> (1)Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care.
> (2) Unlawful sale of controlled substances or other prescription items.
> (3) Patient neglect, physical harm to a patient, or sexual contact with a patient.
> (4) Falsification of medical records.
> (5) Gross incompetence or negligence.
> (6) Theft from patients, other employees, or the employer.
> (c) Failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed ten thousand dollars ($10,000) per violation.
>
> **3758.5**. If a licensee has knowledge that another person may be in violation of, or has violated, any of the statutes or regulations administered by the board, the licensee shall report this information to the board in writing and shall cooperate with the board in furnishing information or assistance as may be required.

Almost half of the complaints received from licensees and employers are for unlicensed practice, the other half fall into one of the six categories identified above in Section 3758(b). The Board also continues to receive criminal convictions, which can be anything from theft to physical abuse to alcohol/drug use/abuse to sexual misconduct. As the mandatory reporting laws are relatively new and as awareness of these laws

comes full circle, the number of complaints received from employers and licensees is expected to climb.

Any enforcement case where discipline is appropriate, will be stipulated if the applicant or licensee is willing to agree to the Board's proposed discipline. This saves thousand of dollars in attorney general and administrative hearing costs (of which only some are recoverable). Stipulations can range from public reprimands, to probationary licenses, to surrenders and revocations. The Office of the Attorney General has been very diligent in trying to settle all cases in a manner acceptable to the Board.

During the administrative process a respondent may request that the Board consider a settlement agreement. At the time the DAG discusses the settlement with the respondent, the DAG considers the proposed probationary terms, which are provided with the case when submitted to the OAG, if applicable. In this way, the Board has determined attorney general costs can be further reduced because the DAG will not have to re-contact the Board to ascertain if a settlement would be considered. The DAG will negotiate the settlement in collaboration with Board staff and by referencing the Board's Disciplinary Guidelines.

If a settlement is agreed upon, the stipulation is prepared and presented to the respondent and his/her attorney, if applicable, for review and signature. The stipulation document will include the basis for the settlement, admissions to the charges in the Accusation or Statement of Issues, the legal basis for imposing the discipline and all conditions for the settlement which may include one or more of the following: cost recovery, suspension, probation, denial of the application, and revocation of licensure.

After the stipulation is signed and returned to the DAG, it is forwarded to the Board, along with a cover memorandum detailing the facts of the case and the recommendation for settlement. The Board then votes by mail on the stipulated settlement. The Board can reject or accept the proposed settlement, or ask for further penalty terms.

If the proposed settlement is adopted, the case is processed and becomes effective as the Board's decision in the matter. If it is rejected, it is returned to the DAG for either additional terms or to have a hearing set in the matter.

Employee/Patient Records

As a result of the new mandatory reporting laws, the Board has run into several obstacles in obtaining employee and patient records. Sometimes these documents are fairly simple to obtain by way of letter or probation monitor personally retrieving the records under the authority of Section 3717, which states,

> **3717**. The board, or any licensed respiratory care practitioner, enforcement staff, or investigative unit appointed by the board, may inspect, or require reports from, a general or specialized hospital or any other facility or corporation providing respiratory care, treatment, or services and the respiratory care staff thereof, with respect to the respiratory care, treatment, services, or facilities provided therein, or the employment of staff providing the respiratory care, treatment, or services, and may inspect respiratory care patient records with

respect to that care, treatment, services, or facilities. The authority to make inspections and to require reports as provided by this section is subject to the restrictions against disclosure contained in Section 2225. Those persons may also inspect employment records relevant to an official investigation provided the written request to inspect the records specifies the portion of the records to be inspected.

However, the ambiguity of the law, in many cases, prevents Board staff from obtaining copies of data needed for investigative purposes and/or evidence. In most cases, hospitals will allow staff to inspect records, but will not allow staff to copy those records without a patient authorization or subpoena. In turn, staff will attempt to contact a patient if the complaint involves patient care, to obtain a release of patient records. This is usually a time-consuming process that rarely proves to be successful. If the complaint does not involve a patient and/or the records cannot be obtained any other way, the case is referred to the Division of Investigation to obtain the records, via subpoena. This method is timely and expensive.

The following statistics reflect that Disciplinary Actions have increased significantly in the last fiscal year. This data reflects the decline in disciplinary action taken for minor violations (i.e. driving under the influence convictions) and the increase in complaints received from employers and licensees as a result of the new mandatory reporting laws.

COMPLAINTS / INVESTIGATION / ACCUSATIONS / STATEMENT OF ISSUES DISCIPLINARY ACTIONS				
	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
COMPLAINTS RECEIVED	225	232	182	239
Complaints Closed	259	261	225	216
Referred for Informal Investigation	208	213	182	239
Referred for Formal Investigation	17	19	38	21
Accusations Filed	74	67	78	82
Acc. and/or Petition to Revoke Filed	30	25	38	23
Statement of Issues Filed	5	9	21	9
Disciplinary Actions	114	91	101	148

CASE AGING DATA

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The following charts summarize the timelines for processing complaints, case investigations, completed investigations to formal charges being filed, and from filing of the accusation or statements of issues to final disposition of a case.

The time frame for investigation and final resolution of disciplinary cases is a shared responsibility between the Board, and the Office of the Attorney General (OAG), and sometimes the Division of the Investigation (DOI). Once a case has been sent to the DOI, the pace at which that investigation is completed rests with the DOI. Likewise, once a case has been sent to the OAG the pace at which the case is processed, settled or scheduled for hearing is within the sole domain of the Office of the Attorney General. The Board does track the activities of cases at the DOI and OAG and periodically requests updates for cases pending more than 90 days.

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Complaint Processing/Informal Investigations & Formal Investigations*	125	120	130	141
Pre-Accusation**	33	69	98	145
Post-Accusation***	282	217	162	156
TOTAL AVERAGE DAYS**	**440**	**406**	**390**	**442**

* Estimated Median – Also includes time lapsed for expert review
**From completed investigation to formal charges being filed.
***From formal charges filed to conclusion of disciplinary case.
****From date complaint received to date of final disposition of disciplinary case.

Complaint Processing

Following is a chart that provides the general timelines to process a complaint including informal investigations and expert reviews.

INFORMAL INVESTIGATIONS CLOSED WITHIN:	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01	AVERAGE % CASES CLOSED
90 Days	103	91	57	65	**36%**
180 Days	51	87	46	37	**25%**
1 Year	59	34	32	58	**21%**
2 Years	22	12	38	29	**12%**
3 Years	5	13	12	2	**4%**
Over 3 Years	4	4	10	1	**2%**
Total Cases Closed	**244**	**241**	**195**	**192**	

The Board has undertaken the responsibility for ensuring that cases are processed as thoroughly and expeditiously as possible in-house. In order to streamline the processing of complaints, Board staff obtain all arrest and court documentation for applicants and in all complaint cases where applicable. By implementing this process in complaint cases, the Board has realized savings both for enforcement costs and complaint case aging. All complaints undergo an informal investigation by staff. Where staff cannot readily attain documents or information, the case is referred to the Division of Investigation for a formal investigation.

Until July 2001, the Board had few RCP experts. This caused a substantial delay in processing those cases where expert review was needed. In fact, those cases that were pending for a year or longer were due to the need for expert review or applicants' or complainants' failure to provide additional information timely.

Formal Investigations

The following chart indicates the time frame in which cases sent for formal investigation are completed:

FORMAL INVESTIGATIONS CLOSED WITHIN:	7FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01	AVERAGE % CASES CLOSED
90 Days	1	0	3	0	**5%**
180 Days	4	3	5	0	**14%**
1 Year	1	10	11	8	**33%**
2 Years	7	3	8	11	**32%**
3 Years	1	4	2	5	**14%**
Over 3 Years	1	0	1	0	**2%**
Total Cases Closed	**15**	**20**	**30**	**24**	

Prosecution

The following chart indicates the time frame in which cases are processed at the Office of the Attorney General. The Office of the Attorney General has made great strides in improving its services in the last 2 years, by reducing the time frame to process most cases and still accommodate the increase in cases. Cases that are taking more than 1 year to complete are a result of the need for expert review or delays in hearing dates. The total cases closed by the Office of the Attorney general increased by 60% from FY 1998/99 to FY 2000/2001.

The Office of the Attorney General, specifically, Carlos Ramirez, Senior Assistant Attorney General, has made great efforts to ensure the Board is satisfied with services rendered. Mr. Ramirez has accommodated the Board when needed and made changes as appropriate. After 8+ years of struggling with the Office of the Attorney General for better service from southern California offices (both quality and quantity), Mr. Ramirez has found solutions to our concerns. The Office of the Attorney General has proven in the last two years, that customer service is a very high priority, which in turn, provides greater consumer protection.

AG CASES CLOSED WITHIN:	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01	AVERAGE % CASES CLOSED
1 Year	51	50	76	98	**61%**
2 Years	46	32	22	38	**31%**
3 Years	9	5	1	10	**6%**
4 Years	7	3	1	0	**2%**
Over 4 Years	1	1	1	0	**<1%**
Total Cases Closed	**114**	**91**	**101**	**146**	
Disciplinary Cases Pending	**79**	**88**	**130**	**92**	

CITE AND FINE PROGRAM

The Board has the authority (B&P section 3761(c)) to cite and fine an individual for representing him or herself to be a respiratory care practitioner without a license granted under the Respiratory Care Practice Act.

The Board actually has a number of options it may take when allegations of misrepresentation are substantiated. These include referral to the district attorney's office for coordination of an arrest and conviction, issuing a citation and fine, issuing a notice of violation, or denial of a license. For licensees who fail to renew a license, the Board may place a "hold on the issuing of a renewal license," issue a notice of violation, and refer the matter to the Office of the Attorney General for appropriate action.

In 1996, California Code of Regulations, Title 16, Division 13.6, Article 7, Sections 1399.375 and 1399.376 were adopted and set forth the guidelines for the issuance and appeal of administrative citations and fines. This process enables the Board to impose a penalty immediately upon those who are found to be in violation of section 3760 (a), misrepresentation, which may include applicants representing themselves as RCPs or licensees who failed to renew their licenses and continue to practice. Previously, when the Board took disciplinary action it incurred all the expenses associated with formal disciplinary action. These costs ranged from $90, $95 and $125 an hour for each service provided by the Division of Investigation, Office of the Attorney General, and Office of Administrative Hearings, respectively. Decisions rarely resulted in revocation or denial of an application, but rather resulted in the issuance of a probationary license with terms and conditions including payment of the actual cost of the investigation and prosecution and the cost for monthly probation monitoring. These costs range from $3,000 to as much as $10,000 for a contested case.

As you can see by the chart below, the Board has saved thousands of dollars that it may have not been successful in recouping through cost recovery, by issuing citations and fines.

CITATIONS AND FINES	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Citations With Fines	39	24	14	14
Amount Assessed	$39,000	$24,000	$14,000	$14,000
Reduced, Withdrawn, Dismissed	2	1	0	1
Amount Collected	$24,000	$14,400	$23,000	$14,400

The Board's Strategic Plan includes the enhancement of the cite and fine program in order to monitor, align and further develop the cite and fine program for the Board. The cite and fine program is a tool for the enforcement program which serves to assist in detection and curtailment of violations of the practice act. The Board is committed to reviewing its enforcement process in the coming months, to see if there are not other violations where cite and fine may be appropriate discipline.

RESULTS OF COMPLAINANT SATISFACTION SURVEY

CONSUMER SATISFACTION SURVEY RESULTS*					
QUESTIONS	**RESPONSES**				
# Surveys Mailed: 55 **# Surveys Returned: 17**	***Very Satisfied***				***Dissatisfied***
	5	**4**	**3**	**2**	**1**
1. Were you satisfied with knowing where to file a complaint and whom to contact?	10	5	1	0	1
2. When you initially contacted the Board, were you satisfied with the way you were treated and how your complaint was handled?	10	3	2	1	1
3. Were you satisfied with the information and advice you received on the handling of your complaint and any further action the Board would take?	9	3	0	2	3
4. Were you satisfied with the way the Board kept you informed about the status of your complaint?	3	6	1	1	5
5. Were you satisfied with the time it took to process your complaint and to investigate, settle, or prosecute your case?	4	4	3	2	4
6. Were you satisfied with the final outcome of your case?	7	1	2	0	6
7. Were you satisfied with the overall service provided by the Board?	**4**	**6**	**2**	**2**	**3**
OVERALL TOTALS	**47**	**28**	**11**	**8**	**23**

In conducting this survey, the Board gathered a sample of complaints made by the public and licensees and requested each complainant to complete the above survey. 31% of the surveys mailed were returned.

The survey results reveal that most complainants were satisfied with all of the areas noted in the survey, as follows:

- Knowing where to file a complaint and whom to contact
- The way the complaint was handled and the way they were treated
- The information and advice received on the handling of the complaint
- The way the information was provided about the status of the case
- The time it took to process the complaint
- The final outcome of the case
- The overall service provided by the Board

Of the 31% returned, nearly all complainants were satisfied or very satisfied with knowing where to file a complaint, and how Board staff treated them. All complainants were either very satisfied or not satisfied with the information and advice they received regarding their complaints and what further action would be taken.

The responses revealed that more than ½ of the complainants were satisfied with the way the Board kept them informed of the status of the complaint, yet there were 5 that were very dissatisfied. The Board has taken immediate action to improve this process by revising the existing notification form and developing stringent policies that will ensure the complainant is notified of each step of the case.

Responses also indicated that it was split fairly evenly across the Board in regard to their satisfaction or dissatisfaction of the time it took to process the complaint. As stated previously, processing time is a shared responsibility between the Board, the Office of the Attorney General and in some cases the Division of Investigation. It is believed that this response could be improved by increasing the attention given to informing complainants about the status of the case on a regular basis. So while, processing times may remain, at least the complainant will have a full picture of what is involved to process the case.

Again, there was a split among responses as to the outcome of the complaint with approximately ½ very satisfied and the other ½ very dissatisfied. Unfortunately, 3 of the 6 responses indicated a “1” for this area, because they were never advised of the outcome. The other 3 thought the discipline should have been much harsher. As a result of the responses where complainants were not aware of the outcome, staff prepared and disseminated letters (in August, 2001) to the complainants advising them of the final outcome.

In response to the overall service of the Board, 12 or 71% were satisfied or more than satisfied and 5 or 29% were not satisfied. Clearly, the survey indicates that the Board is doing a fairly good job in responding to consumer’s complaints. At the same time, it also indicates those areas that could use improvement to which the Board has responded.

ENFORCEMENT EXPENDITURES AND COST RECOVERY

AVERAGE COSTS FOR INVESTIGATIVE CASES

AVERAGE COST PER CASE FORMAL INVESTIGATION	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Cost of Formal Investigation	**$60,200**	**$58,600**	**$116,400**	**$43,600**
Number of Cases Referred for Formal Inv.	17	19	38	21
Average Cost Per Formal Investigation	**$3,500**	**$3,100**	**$3,100**	**$2,100**

The Division of Investigation (DOI) conducts all of the Board's formal investigations and may include one or more of the following:

- Interviews
- Subpoenas
- Inspection of facilities
- Collection and analysis of records and evidence
- Audit of patient records
- Biological fluid testing
- Undercover operations
- Personal interviews and declarations from subjects, complainants, employees, witnesses, and law enforcement personnel
- Coordination of an investigation with other government or law enforcement agencies

Complex complaints and complaints filed in accordance with the Board's new mandatory reporting laws that are related to patient care often require DOI's intervention. It is estimated that half of the cases referred to the DOI are a result of hospitals and employers refusing to provide copies of records to the Board at the Board's written request. Rather a subpoena is necessary to obtain these records. DOI's hourly rate is generally $100 per hour (hourly rate determined at the close of fiscal year) and can take anywhere from 4 to 15 hours or $400 to $1,500 to obtain the records.

Other investigations are generally very complex requiring several investigative techniques as described above. Costs to investigate these cases are generally the most expensive ranging from $1,500 to $5,000.

The Division of Investigation has been very effective in meeting the Board's needs to gather evidence. The DOI has scheduled meetings with our Board over the past four years to make sure our needs are being met and they are always willing to assist or make accommodations as needed.

AVERAGE COSTS FOR EXPERT WITNESS REVIEW AND/OR TESTIMONY

AVERAGE COST PER CASE for EXPERT REVIEW	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Cost for Expert Review/Testimony	$8,000	$18,600	$17,100	$15,100
Number of Cases Reviewed	4	8	18	15
Average Cost Per Case	**$2,000**	**$2,300**	**$1,000**	**$1,000**

The Board often utilizes an expert witness to determine negligent practice based on the criterion of community standards. Cases that involve patient negligence or unprofessional conduct are sent to expert respiratory care practitioners for review. With the new mandatory reporting laws, many complaints require expert review. Until July 2001, the Board had only a handful of experts. However, the Board has been actively recruiting for expert witnesses with its latest effort being in its June 2001 newsletter. Currently, the Board has a backlog of 10 complaints that are either pending in our office or at the Office of the Attorney General for review. Now that the Board has gained a pool of experts, this backlog is expected to diminish within the next few months.

AVERAGE COSTS FOR AG PROSECUTION

AVERAGE COST PER CASE REFERRED TO AG	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Cost of Prosecution	254,400	223,700	298,000	304,500
Number of Accusations/SOI Filed	109	101	137	114
Average Cost Per Case	**$2,300**	**$2,200**	**$2,200**	**$2,700**

In the last two years, the Office of the Attorney General has made great strides to accommodate the Board. The Board has had a history of meeting with the Office of the Attorney General to see that cases are prosecuted timely and costs billed by specific attorneys were reduced. Though little progress was made in the past, the Office of the Attorney General has made great strides to provide a quality product and at the same time processing more cases [above data does not include the cases settled].

Although costs in the last fiscal year have increased, this can be attributed to higher hourly costs and more complex cases as a result of the new mandatory reporting laws. Although, this is not a scientific method to determine the average cost per case (as there are many variables to each case and caseload type can fluctuate from year to year), you will note that costs per case for the previous years was declining even in spite of higher hourly rates. Carlos Ramirez, Senior Assistant Attorney General is credited for seeing that the Board's cases are handled as efficiently as possible. In the last two years, Mr. Ramirez has been very proactive in ensuring that the Board's needs are met and that the service provided is acceptable.

AVERAGE COSTS FOR ADMINISTRATIVE HEARINGS

AVERAGE COST PER CASE HEARING HELD	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Cost of Hearings	76,000	60,600	46,300	77,200
Number of Cases Heard	31	18	19	19
Average Cost Per Case	**$2,500**	**$3,400**	**$2,400**	**$4,100**

Administrative Hearing costs include services provided for the hearing officer and court reporter, filing fees, and invoices for transcriptions.

COST PER CASE - TOTALS

COST PER CASE TOTALS	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Attorney General Only	$2,300	$2,200	$2,200	$2,700
AG and Hearing	$4,800	$5,600	$4,600	$6,800
Formal Investigation and AG	$5,800	$5,100	$5,100	$4,800
Formal Investigation, AG, and Hearing	$8,300	$8,500	$7,500	$8,900
Expert Review and AG	$4,300	$4,500	$3,200	$3,700
Expert Rvw, Formal Investigation, and AG	$7,800	$7,400	$6,100	$5,800
Expert Rvw, Formal Inv., AG, and Hearing	$10,300	$10,800	$8,500	$9,900

The cost to investigate and prosecute a case generally varies from $2,500 to $5,000. The total cost depends greatly on whether: the case is sent for formal investigation, an expert is utilized to review the case, the case goes to hearing and if witnesses are needed. The median cost for disciplinary cases is $2,000 and these cases do not generally require formal investigation or go to hearing. However, with the new mandatory reporting laws, this figure is expected to rise, as many of these cases require expert review.

COST RECOVERY EFFORTS

Pursuant to B&P Sections 3753.1, 3753.5, and 3753.7, the Board has the authority to recoup its actual costs associated with the investigation and prosecution of disciplinary cases where the respondent has committed a violation of law and for the costs associated with monitoring a probationary order.

The Board's statute is unique in that the word reasonable as previously used in section 3753.5 was deleted (1992, Ch. 1289 – AB 2743, Frazee), therefore requiring any practitioner or applicant to "…pay to the board a sum not to exceed the [actual] costs of the investigation and prosecution of the case." The Board later added the ability to assess costs to applicants and the ability to increase the costs awarded [not to exceed actual investigative and prosecution costs] in the event a case is non-adopted.

In December 1996, the Board joined in the Interagency Intercept Collections Program managed by the Franchise Tax Board (FTB). This program allows for collection and

interception of both tax refunds and lottery winnings from individuals who owe delinquent cost recovery amounts. The Board has recovered over $40,000 through the FTB.

The Board is committed to collecting costs from those individuals that incur the expenses. This is because the "good" practitioners--individuals who practice safely and obey all laws—do not want to pay the full cost for removal of the "bad" practitioner. This is why the Board has been so diligent in getting costs awarded.

Attorney costs associated with representing the Board at hearings and administrative hearing costs are not recoverable. The Board would like to seek a legislative amendment to recoup hearing costs in the 2002 legislative year.

The chart below indicates that of "Total Enforcement Expenditures" an average of 60% of costs are awarded. And of those awarded, approximately 29% of costs are recovered. The dollar amount is significant to the Board's fund, and the Board has sought other avenues to recover more costs ordered.

COST RECOVERY DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Enforcement Expenditures*	$398,600	$361,500	$477,800	$440,400
# Potential Cases for Recovery**	147	84	118	163
# Cases Recovery Ordered	142	78	114	156
Amount of Cost Recovery Ordered	$293,687	$212,607	$260,567	$241,747
Amount Collected	$71,000	$74,000	$74,000	$78,300

* Expenditures are taken from costs depicted in the previous charts for investigation, expert witness, attorney general, and administrative hearings. Due to the Department's method of assessing investigative costs (a.k.a. rollover method) investigative expenses reported on Calstars do not reflect actual expenditures for services provided during a specific fiscal year. Further, total expenditures do NOT include personnel and operating expenses associated with enforcement.

**The "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation, or violations, of the License Practice Act.

The Board also has the authority to recover all costs associated with monitoring probationers from RCPs placed on probation. The following chart demonstrates the costs to perform probation monitoring and the costs recovered:

PROBATION MONITORING COST RECOVERY DATA	FY 1997/98	FY 1998/99	FY 1999/00	FY 2000/01
Total Probation Monitoring Expenditures	$197,000	$197,000	$297,000	$297,000
No. of Active Probationers	165	173	171	169
Estimate of Probation Monitoring Costs to Collect	$198,000	$207,600	$205,200	$202,800
Amount Collected	$110,600	$109,500	$105,500	$119,800

The Board conducted research to see if a possible contractual agreement with private collections agencies, could improve cost recovery collected. It was found that collection agencies will work on commission collecting a small percentage of the total amount recovered. However, it was also found that collection agencies require social security numbers in order to pursue recouping costs, to which the Board is prohibited from releasing for this purpose. A legislative amendment to allow Boards to release social security numbers for the sole purpose of collecting costs awarded would greatly benefit all Boards and Bureaus for this purpose.

Another possible method to improve the collection of costs, may be for the Department to centralize this function for all boards. However, this method would probably prove to not be as cost effective as using private collection agencies since private collection agencies operate on commission.

RESTITUTION PROVIDED TO CONSUMERS

The Board does not have the authority to issue restitution administratively nor does it have the authority to improve or enhance criminal penalties or sanctions. However, the Board will provide appropriate documentation to the District Attorney in cases where a criminal case is pending regarding a practitioner. Although the Board may refer cases to the District Attorney or City Attorney providing a comprehensive DOI (peace officer) investigation, often these offices choose not to prosecute.

The Board has no authority to mandate restitution to consumers, although the terms of probation include that the probationer will adhere to any terms of criminal probation, which may include a requirement to provide restitution.

Further, the types of complaints processed by the Board to date, do not generally involve situations or complainants where restitution would be awarded. However, with the new mandatory reporting laws this may become a concern in the future.

COMPLAINT DISCLOSURE POLICY

The public has access to formal disciplinary actions such as accusations (including statements of issues), final decisions and citations. The Board discloses and provides disciplinary information and documentation upon request and in accordance with the Public Records Act, section 6251, et. seq. of the Government Code.

Initially, in April 1993, the Board developed its complaint disclosure policy to include any cases that had been transmitted to the Office of the Attorney General as public information. However, the Medical Board of California had a similar complaint disclosure policy, which provided more in-depth information, and was subsequently sued. The litigation was both substantial and costly and ultimately ended with the judge determining that the policy violated due process. As a result of this case, the Office of the Attorney General has advised against disclosing any enforcement-related information until a pleading is filed.

As such, the Board adopted a revised complaint disclosure policy on May 18, 2001, as follows:

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It is the policy of the Respiratory Care Board of California (Board) to disclose complaint information concerning a licensee or applicant only after a formal charge is filed by the Office of the Attorney General.

Information that will be disclosed includes:

The type of action (i.e. Accusation or Statement of Issues) and the information disclosed in the pleading.

The status of the action if a formal decision has not been rendered.

The final decision and any discipline imposed.

Any information the Board has as to whether the District Attorney/City Attorney has the case for review or has filed criminal charges and any criminal penalties imposed.

Once a pleading is filed, the Board will provide any and all information included in the pleading and will offer a copy of the pleading to the inquirer.

The following chart indicates the information disclosed to the public:

TYPE OF INFORMATION PROVIDED	YES	NO
Complaint Filed		X
Citation	X	
Fine	X	
Formal Reprimand	X	
Pending Investigation		X
Investigation Completed		X
Referred to AG: Pre-Accusation		X
Referred to AG: Post-Accusation	X	
Settlement Decision	X	
Disciplinary Action Taken	X	

Once an accusation (including statements of issues) is filed, the Board will disclose any and all information contained in the pleading, including any criminal convictions.

Further, complainants are provided more information in a case, including whether an investigation was initiated or performed and whether the case was forwarded to the Office of the Attorney General. Specific information, other than the status of the case, will not be released until a formal pleading has been filed.

CONSUMER OUTREACH, EDUCATION AND USE OF THE INTERNET

As part of its goals and objectives for the future, the Board has committed to enhancing its public relations and consumer outreach. Specifically, the Board would like to promote awareness of its mission and authority and raise awareness of patients' rights. Also, the Board would like to maintain a rapport with the respiratory care industry and disseminate pertinent legislative, regulation, and policy information to licensees regularly.

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The Board has made great strides in the area of consumer and licensee/applicant outreach. Previously, outreach efforts were severely thwarted by the Board's low fund reserves. Since the Board's last Sunset Review, it has developed its own website, begun distribution of its newsletter, participated at the most recent convention for a respiratory care association, and has just recently agreed to enter into an agreement if legally appropriate, to participate in a national disciplinary database.

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The Board believes the Internet is the most cost-effective mechanism to provide consumers with easily accessible information regarding RCP licensure and enforcement. On June 29, 2001, the Board's website was established in accordance with the Governor's new guidelines [www.rcb.ca.gov]. At this time, the website includes information regarding the licensure and enforcement processes, discipline taken, and makes several forms available. An e-mail address is provided for any user to make any inquiry. E-mail messages are checked daily and responses are provided in a timely fashion (1-2 business days). The site also gives notice of public meetings in accordance with Government Code §11125(a) (AB 1234, Statutes of 1999, Chapter 393). The following important information and forms will be on the site as soon as possible:

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- ➡ Application for Licensure and Instructions
- ➡ Board Member Information
- ➡ Consumer Complaint Form
- ➡ Press Releases
- ➡ Approved Foreign Evaluation Centers
- Complete Fee Schedule
- California Respiratory Care Programs Newsletters
- Board's Scope of Practice Database

In fact, by the time the Board is up for its Sunset Hearing, the website should include most, if not all, of this information. The Board has also entered into a contract to have the Department of Consumer Affairs develop and maintain its "License Look-Up" component. This is a mechanism that allows any person with access to the Internet to check on the license status of any respiratory care practitioner by name or license number. This is expected to be up and running before July 1, 2002.

The Board's website does provide a form for applicants and licensees to submit address changes and it plans to provide more information regarding the renewal of a license in the near future. The Department of Consumer Affairs (DCA) has assisted three other Board/Bureaus with processing renewals on-line. Once the Department offers this service to all Boards and Bureaus, the Board will consider on-line license renewal very seriously.

The Board's website is a vital tool in communication between, consumers, applicants, licensees, program directors and other entities. Board staff will continually modify and update the site with additional information and make it as user friendly as possible.

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The Board's first newsletter in several years was disseminated in July 2001. This newsletter was sent to each respiratory care practitioner licensed in California. This particular newsletter advised of the Board's new mandatory reporting laws and advertised for expert witnesses. As discussed earlier, the new mandatory reporting laws have established a large pool of complaints that are directly related to the practice. As a result, the Board needs to maintain a sufficient pool of RCPs to act as experts in determining a violation of the Practice Act. Further, since notoriety of the profession is relatively low as compared to doctors and nurses, and the fact that many RCP patients are comatosed, most complaints are received from fellow RCPs or employers. Especially, now that they are mandated to report this information. Keeping the profession apprised of enforcement issues is a key to protecting consumers. The Board plans to issue newsletters biannually and future newsletters will inform licensees of pending Board business so that they may be apprised of the issues facing the Board and take action accordingly.

In 2000, the Board was invited to participate at a convention sponsored by a respiratory care society. In June 2001, the physician and surgeon member of the Board gave a presentation at the conference and staff were present at a booth to respond and/or take inquiries, suggestions or concerns. Staff promoted awareness of its complaint reporting processes by providing copies of its laws and regulations and mandatory and consumer complaint information to nearly 350 people associated with the respiratory care profession.

In August 2001, the Board directed staff to move forward in researching the legalities of entering into an agreement with the National Board for Respiratory Care (NBRC) to participate in the National Respiratory Care Disciplinary Database. Currently, 29 of the states that have licensure laws participate by submitting records regarding state disciplinary actions for inclusion in the database. Participating states receive quarterly reports and will soon be able to electronically access the database. Access to this database will be helpful as a few RCPs have been known to leave one state because of disciplinary action and seek licensure in another state. The Board will be working with the NBRC on appropriate language for the contract/agreement.

The Board does not foresee offering its examination via Internet. Though the exam is computer-based, security and applicant verification protocols are still maintained. Allowing the examination to be offered via Internet, even in a secured environment, does not pose any benefits and actually places risk for contamination. Further, the Board is bound by the examination guidelines of the national testing agency, which does not provide for testing via the Internet. At this time, it is not feasible for the Board to develop and maintain its own examination for this sole purpose.

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The Board has not found the practice of respiratory care being conducted over the Internet. Therefore, the Board has no plans to regulate Internet RCP practice.

PART 2.

RESPIRATORY CARE BOARD

BOARD'S RESPONSE TO ISSUES IDENTIFIED AND FORMER RECOMMENDATIONS MADE BY THE JOINT LEGISLATIVE SUNSET REVIEW COMMITTEE

ISSUE #1 Should the State's licensing of respiratory care practitioners be continued?

BACKGROUND

1998 Recommendation
Both the Department and Committee staff recommended the continued licensure of respiratory care practitioners (RCPs).

1998 JLSRC Comments
Medical patients rely on RCPs for critical services requiring professional judgment and complex, technical skills which, if performed in competently, could cause patient harm or death. Licensure helps ensure that the practice of respiratory care by RCPs is carefully monitored, controlled, and regulated to minimize problems of incompetence and patient endangerment. The practice of respiratory care is regulated in 35 states.

SUBSEQUENT LEGISLATION
SB 1980 (Statutes of 1998, Chapter 991) extended the Respiratory Care Board's inoperative date from July 1, 1999 to July 1, 2003.

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ISSUE #2 Should an independent Respiratory Care Board be continued, or should its operations and functions be assumed by the Department of Consumer Affairs?

BACKGROUND

1998 Recommendation
Both the Department and Committee staff recommended that the Respiratory Care Board be retained as the state agency to regulate and license RCPs. Committee staff recommended that the sunset date of the Board be extended for four years (to July 1,

2003). However, the Board should report to the Legislature within two years, on what efforts it has made to rectify its budgetary problems and revise its enforcement program. (Both of these issues are discussed further in this document).

1998 JLSRC Comments

The Board has demonstrated a high level of innovation and a strong consumer protection focus. There does not appear to be any compelling reason to believe that there would be any savings or increased performance if the Board were sunseted and its functions assumed by the Department. However, the Board must reduce expenditures and prioritize spending to resolve its budget problems. Because of the Board's projected deficit situation and unresolved issues with its enforcement program, the Board should be required to report to the Legislature within two years on efforts it has made to rectify these problems.

SUBSEQUENT LEGISLATION/ACTION

SB 1980 (Statutes of 1998, Chapter 991) extended the Respiratory Care Board's inoperative date from July 1, 1999 to July 1, 2003.

In addition, SB 1980, added section 3712.5 of the Business and Professions Code which states, "The Respiratory Care Board shall report to the Legislature on or before October 1, 2000, as to what efforts it has made to rectify its budgetary problems and revise its enforcement program.

On September 29, 2000, the Respiratory Care Board issued a letter to the Honorable Liz Figueroa, Chairperson of the Joint Legislative Sunset Review Committee (JLSRC), explaining the steps the Board took to rectify its budgetary problems and revise its enforcement program. A copy of that letter is attached.

In addition, the Board testified before the JLSRC on December 6, 2000, on these same issues.

ISSUE #3 Should the size or composition of the Respiratory Care Board be changed?

BACKGROUND

1998 Recommendation

This Board has 9 members, of which 4 are licensed RCPs, 2 are physicians, and 3 are public members. The Department generally recommends a public member majority and an odd number of members for regulatory boards. For the Respiratory Care Board, the Department recommended that the limitations on what types of licensed practitioners serve on the Board be removed, making it easier for the appointing authorities to appoint qualified candidates. Additionally, the Department recommended that the current appointment of 3 members by the Senate, 3 members by the Assembly and 3 members by the Governor be changed so that the Governor

would make all appointments except for two. Committee staff did not agree with changing the number of appointments by the Senate and the Assembly. However, consistent with the Department's recommendation for increased public membership, Committee staff recommended removing one physician member from the Board and adding one public member. The composition of the Board would still be 9 members, but with 4 RCPs, 4 public members and 1 physician member.

SUBSEQUENT LEGISLATION

SB 1980 (Statutes of 1998, Chapter 991) changed the Board composition from 2 physician and surgeons, 4 respiratory care practitioners and 3 public members to 1 physician and surgeon, 4 respiratory care practitioners and 4 public members. Each of the three appointing authorities continue to appoint 3 members. See page 4 of Part One of this report for more information on appointments.

ISSUE #4 Should the Board seek a fee increase to improve its budget situation?

BACKGROUND

1998 Recommendation

Both the Department and Committee staff agreed that the Respiratory Care Board has experienced major fiscal problems and may need to seek a fee increase, but only after providing appropriate justification to the standing and appropriation committees of the Legislature. However, prior to implementing the increase, the Board should also explore additional means of balancing revenues and expenditures, including curtailing programs and services that are not mandatory. In addition, the Board should restructure its enforcement program and prioritize enforcement spending.

SUBSEQUENT LEGISLATION/ACTION

SB 1980 (Statutes of 1998, Chapter 991) amended section 3775 of the Business and Professions Code, increasing the statutory ceiling of the Board's application, initial license, and renewal fees.

These fees have not yet been raised. SB 1980 actually states that the renewal fee shall be $230, which was a $30 increase from the renewal fee charged at that time. The Board did not implement this increase as expenditures were reduced and the Board's fund was sufficient. The Board's renewal fee continues to be $200. However, the Board does plan to implement the $230 renewal fee on January 1, 2002.

The Board was successful in curtailing many of its enforcement activities (discussed later) to delay the implementation of the renewal fee increase by three years. Although the Board's expenditures continue to exceed its revenues, this is a result of increased complaints received from mandatory reporting. Further, the Board's fund is projected to remain solvent through FY 2004/05.

In light of complaints received from the new mandatory reporting laws, the Board recognizes that it must again revisit its disciplinary guidelines and prioritize the types of complaints it pursues to ensure that enforcement expenditures are contained. In August, 2001, the Board decided to develop a plan of action to address the revision of its disciplinary guidelines and prioritizing cases in accordance to budgetary restraints in 2002.

ISSUE #5 Should the Respiratory Care Board restructure its enforcement program? Should the current Board's practice of discipline applicants and licensees for prior criminal convictions be continued?

BACKGROUND

1998 Recommendation

Both the Department and Committee staff recommended that the Board prioritize its enforcement spending and only take disciplinary action against those applicants and licensees who exhibit incompetence, and have committed criminal offenses that are substantially related to the ability to practice respiratory care.

SUBSEQUENT ACTION

At the recommendation of the Joint Legislative Sunset Review Committee, the Board performed an in-depth review of its overall enforcement program. The Board streamlined its enforcement procedures by revising its rehabilitation criteria and disciplinary guidelines, which resulted in a reduction of applicant cases requiring prosecution by the Office of the Attorney General. Statements of Issues filed against applicants dropped dramatically from 45 being filed in FY 96/97 to 5 in FY 97/98, 9 in FY 98/99, 21 in FY 99/00 and 9 in FY 00/01.

Further, SB 809 (Statutes of 1999, Chapter 459) added section 3750.51 to the Business and Professions Code which provides that the Board shall file an accusation against a licensee within three years from the date the board discovers the alleged act or omission that is the basis for disciplinary action, or within seven years from the date the alleged act or omission that is the basis for disciplinary action occurred, whichever occurs first. However, this legislation had little impact in the way the Board normally conducted its business and no significant changes or savings were realized.

In 1997, the Board implemented and continues to cite and fine individuals for violation of Business and Professions Code, section 3761(a), misrepresentation. Cite and fine is generally the preferred method rather than formal discipline. This has directly decreased the number of costly enforcement cases, which were previously administratively prosecuted.

The Board moved forward in implementing regulations requiring a higher minimum education standard for all respiratory care practitioner applicants effective July 1, 2000. This too has resulted in fewer applicants with histories of substance abuse or prior criminal records and is reflected in the Statements of Issues statistics previously noted and in the total number of complaints received. Complaints received dropped from 232 in FY 98/99 to 182 in FY 1999/00.

However, you will notice that complaints begin to rise again to 239 in FY 2000/01. This directly corresponds to the increase in complaints received as a result of the mandatory reporting laws, which went into effect January 1, 1999. The Board has been promoting the new mandatory reporting requirements and expects awareness of the new laws to come full circle with the profession this fall. Complaints received from licensees increased from 11 in FY 1999/00 to 87 in FY 2000/01.

As a result of the increase in complaints and the expenses incurred in processing these types of complaints, the Board recognizes that it must again perform an in-depth review of its enforcement program and possibly revise its disciplinary guidelines. The Board has discussed this matter and the review should be complete by the end of 2002. The Board is committed to finding alternative methods to carry out its mandate without having to increase fees.

ISSUE #6 Should the Respiratory Care Board, as it has recommended, be allowed to initiate a pilot program for temporary license suspension orders in situations of alleged misconduct?

BACKGROUND

1998 Recommendation

The Department does not support the establishment of a pilot project to temporarily suspend a license without the protection of due process. It indicates that the Board has not adequately demonstrated that it is using the authority it already has (use of the administrative Interim Suspension Order (ISO) or the judicial Temporary Restraining Order (TRO)), and that any exceptions to the Administrative Procedure Act could be used as precedents and must be approached with extreme caution. Committee staff agreed and has already recommended a pilot program for the Medical Board to determine if a more immediate procedure is necessary to suspend a practitioner's license.

SUBSEQUENT ACTION

In the last two years, the Board has dramatically improved relations with the Office of the Attorney General. The Office of the Attorney General is now, very client service oriented and the Board has had no problems in acquiring Interim Suspension Orders or achieving other methods to suspend an RCP's practice when warranted. For example, the Board contacted the OAG to obtain an Interim Suspension Order against a RCP accused of sexually assaulting a 14-year old patient. However, rather than try to push through an ISO in two weeks, the OAG suggested that they appear at the RCPs criminal bail hearing and ensure that the Judge handling the case, place a restriction from allowing the RCP to practice. As a result, the restriction was made in only 4 days from the date the Board was notified of the incident (The OAG is also in the process of obtaining an ISO in the event the criminal order is modified). At this time, the Board is no longer interested in pursuing the authority to issue Interim Suspension Orders of its own.

ISSUE #7 Should respiratory care registry companies be required to register with the Board?

BACKGROUND

1998 Recommendation
The Department recommended that further data be provided to support the Board's recommendation for requiring registration of registry firms. The Department could not determine the extent of the problem created by the registries or whether requiring these firms to register is warranted. The Department further recommended that the Board conduct a sunrise process prior to proceeding with an expansion of regulation. Committee staff concurred with this recommendation.

SUBSEQUENT ACTION
As a result of the new mandatory reporting laws, the Board is promoting the requirements for any licensee to report any violation of the act and any employer to report the suspension or termination of an RCP for causes specified in section 3758 of the Business and Professions Code. At this time, the Board believes these new requirements have reduced the incidents of unlicensed practice and is not pursuing the registration of registry firms.

ISSUE #8 Should the Respiratory Care Board be authorized to require mandatory reporting from any employer of a respiratory care practitioner if they terminate an RCP for cause (criminal misconduct, negligent practice, etc.), and from a licensee who knows or has reason to believe that an RCP has violated any statutes or rules administered by the Board?

BACKGROUND

1998 Recommendation
The Department recommended that further data be provided to support the Board's recommendation to require mandatory reporting. Committee staff concurred with the Department.

SUBSEQUENT LEGISLATION/ACTION
As a result of a very publicized case, "the angel of death," the Board was approached by Assemblyman Wildman's office, 1998, to author mandatory reporting legislation for the Board.

AB 123 (Statutes of 1998, Chapter 553) added sections 3758, 3758.5, 3758.6 and 3759 to the Business and Professions Code, which provide for mandatory reporting and read as follows:

§ 3758. Report of Suspended or Terminated Employees.

(a) Any employer of a respiratory care practitioner shall report to the Respiratory Care Board the suspension or termination for cause of any practitioner in their employ. The reporting required herein shall not act as a waiver of confidentiality of medical records. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800, and shall not be subject to discovery in civil cases.
(b) For purposes of the section, "suspension of termination for cause" is defined to mean suspension or termination from employment for any of the following reasons:
(1) Use of controlled substances or alcohol to such an extent that it impairs the ability to safely practice respiratory care.
(2) Unlawful sale of controlled substances or other prescription items.
(3) Patient neglect, physical harm to a patient, or sexual contact with a patient.
(4) Falsification of medical records.
(5) Gross incompetence or negligence.
(6) Theft from patients, other employees, or the employer.
(c) Failure of an employer to make a report required by this section is punishable by an administrative fine not to exceed ten thousand dollars ($10,000) per violation.

§ 3758.5. Report of Suspected Violations.

If a licensee has knowledge that another person may be in violation of, or has violated, any of the statutes or regulations administered by the board, the licensee shall report this information to the board in writing and shall cooperate with the board in furnishing information or assistance as may be required.

§ 3758.6. Additional Reporting Requirements.

In addition to the reporting required under Section 3758, an employer shall also report to the board the name, professional licensure type and number, and title of the person supervising the licensee who has been suspended or terminated for cause, as defined in subdivision (b) of Section 3758. If the supervisor is a licensee under this chapter, the board shall investigate whether due care was exercised by that supervisor in accordance with this chapter. If the supervisor is a health professional, licensed by another licensing board under this division, the employer shall report the name of that supervisor and any and all information pertaining to the suspension or termination for cause of the person licensed under this chapter to the appropriate licensing board.
(1998 ch. 553)

§ 3759. Reporting Immunity.

Pursuant to Section 43.8 of the Civil Code, no person shall incur any civil penalty as a result of making any report required by this chapter.

The Board began promoting awareness of the mandatory reporting requirements in 1999, and expects awareness to become full circle by the end of 2001. Complaints received from licensees and RCP employers have increased dramatically from 5 in FY 1998/99 to 87 in FY 2000/01. The mandatory reporting requirements have proven to be one of the best tools available for the Board to enforce its laws and regulations and protect consumers.

Approximately ½ of the complaints received from licensees and employers in FY 2000/01 were for unlicensed practice. The other ½ fall into one of the categories outlined in Section 3758. As you can see, these violations are very serious in nature. The Board has turned its focus to ensuring that complaints reported under section 3758 receive highest priority as they are individuals who are directly jeopardizing patient care.

Mandatory reporting is a key component in protecting the public. In fact, one employer who reported that an RCP sexually assaulted a 14-year old patient, had informed law enforcement and indicated that he thought only to report it to the Board because of the new mandatory reporting requirements. As discussed earlier, this saved months and possibly years of allowing this RCP to practice. The Board was able to restrict the RCP from practicing within 4 days of notification. However, without mandatory reporting, the Board would have normally found out about the incident, either through criminal investigators contacting the Board at a later date, or worse, through a DOJ rap sheet indicating a conviction a year or more after the fact.

Of course, it would always be preferred to prevent any such behavior as in this case, and the Board does perform vigorous background checks for this reason. However, in this case, the RCP was licensed for less than a year, and had no prior criminal background.

The Board views mandatory reporting as a milestone and a key component in protecting the public.